



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Elite Healthcare Fort Worth

Respondent Name

Arch Insurance Co

MFDR Tracking Number

M4-16-0769-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier shall not withdraw a preauthorization or concurrent review approval once issued."

Amount in Dispute: \$470.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 24, 2015. The insurance carrier did not submit a response for consideration in this review. Per 133.307 (d) (1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." Accordingly, this decision is based on the available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 24, 2015	97140, 97112, 97113	\$470.68	\$357.71

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 24F06 – Per TX Rule 134.600 pre-auth is required
 - 00950 – This bill is a reconsideration of a previously reviewed bill
 - 26951 – We are unable to recommend an additional allowance since this claim was paid in accordance with the State’s fee schedule guidelines

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 24F06 – “Per TX Rule 134.600 pre-auth is required.” 28 Texas Administrative Code §134.600 (p) states in pertinent part,

Non-emergency health care requiring preauthorization includes:

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

Review of the submitted information finds;

An email from Sigal.elite@gmail.com to Alissa_Caceres@gbtpa.com states, “PT is authorized thank you.”

The Division finds the carrier’s denial is not supported as the above mentioned “authorization” placed no limit on days, units, or sessions. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The maximum allowable reimbursement will be calculated as follows;

- Procedure code 97140, service date June 24, 2015. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.43215. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 0.995 is 0.398. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.83787 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$47.09. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$35.90 at 2 units is \$71.80.
- Procedure code 97112, service date June 24, 2015. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for

work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.45225. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.995 is 0.4776. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.93757 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$52.69. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$39.27 at 2 units is \$78.54.

- Procedure code 97113, service date June 24, 2015. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.4422. The practice expense (PE) RVU of 0.76 multiplied by the PE GPCI of 0.995 is 0.7562. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 1.20612 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$67.78. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$67.78. The PE reduced rate is \$46.53 at 3 units is \$139.59. The total is \$207.37.
3. The total allowable reimbursement for the services in dispute is \$357.71. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$357.71. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$357.71.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$357.71 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	December , 2015 Date
--------------------	---	-------------------------

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.